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Submission to the Parliamentary Inquiry into support for children and young people who have been directly or indirectly exposed to trauma associated with migration to Australia due to humanitarian crises.

Prepared by the Association for Services to Torture and Trauma Survivors (ASeTTS)

28 February 2024

Attn: Joint Standing Committee on the Commissioner for Children and Young People

RE: ASeTTS' submission to the Parliamentary Inquiry into support for children and young people who have been directly or indirectly exposed to trauma associated with migration to Australia due to humanitarian crises

The Association for Services to Torture and Trauma Survivors (ASeTTS) welcomes the opportunity to respond to the Parliamentary Inquiry into support for children and young people who have been directly or indirectly exposed to trauma associated with migration to Australia due to humanitarian crises.

As Western Australia's sole provider of torture and trauma rehabilitation services to people from refugee-like backgrounds we believe we have unique insights into the trauma experiences of children, young people and their families who have come to Australia as refugees or asylum seekers, and the supports and services that facilitate recovery and transition to life in Australia. Our attached submission to the Joint Standing Committee on the Commissioner for Children and Young People has been prepared after consultation with ASeTTS' clinicians and draws on our 32-years of experience delivering specialist services to children and young people from refugee-like backgrounds who have experienced torture or trauma in their country of origin, during their journey to Australia, or while in detention.

In our response we provide an overview of our services and programs, along with data and information about the very diverse people, families, and communities we support. Interspersed throughout are de-identified case studies that explore the specific challenges that the children and young people we support have faced. This includes being part of a family that is impacted by complex multilayered trauma, challenges with accessing public and community mental health services, and engagement with the education system.

We end the submission with specific recommendations for the Joint Committee to consider, including:

- Providing committed ongoing funding to specialist refugee mental health providers to improve the continuity of services and improve capacity to support young people from refugee-like backgrounds.
- Embedding cultural awareness and cultural safety practices in public and community mental health services.
- Improving public mental health services to ensure they deliver preventative services rather than waiting until children and young people and their families are in crisis.
- Increasing school-based services and supports that assist children from CaLD and refugee-like backgrounds and developing a consistent approach to engaging external specialist supports.
- Ensuring the voices and experiences of children, young people and families from refugee-like backgrounds should be heard and considered in the development of service improvements.

We welcome further discussion about this letter and the attached paper.

Please direct enquiries to the ASeTTS' CEO, Ms Merissa Van Der Linden at ceo@asetts.org.au.

Yours sincerely,

Merissa Van Der Linden
Chief Executive Officer
ASeTTS

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Submission to the Parliamentary Inquiry into support for children and young people who have been directly or indirectly exposed to trauma associated with migration to Australia due to humanitarian crises

1. About ASeTTS

ASeTTS was established in 1992 to provide specialist mental health and rehabilitation services to asylum seekers and people from refugee-like backgrounds who have experienced torture or trauma in their country of origin, during their journey to Australia, or while in detention. Our services are designed for people who have arrived as refugees, asylum seekers, humanitarian entrants, people with permanent protection visas, and people from these backgrounds who have since become permanent residents or citizens in Australia.

The organisation is a member of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)[1]; a network of eight (8) specialist rehabilitation agencies that support survivors of torture and trauma across Australia, and a member of the International Rehabilitation Council for Torture Victims (IRCT)[2]. The IRCT is a civil society organisation that specialises in torture rehabilitation and has close to 160-member centres operating in 76 countries worldwide. As a member of FASSTT, ASeTTS has the ability to draw on the collective wisdom and experience of the national network; a network that combined has over 250 years' experience supporting refugee survivors of torture and trauma.

ASeTTS is a quality accredited mental health service provider, that delivers services through funding provided by Commonwealth and State government agencies and philanthropic donors. Unlike mainstream mental health service providers ASeTTS' therapeutic services are not time limited. Our funders and supporters recognise that recovery from torture and trauma takes time and often requires different supports and intervention at different points of time. People who have in the past accessed our services, are welcomed to re-enter services as they are needed and required. Our services are free of charge and are provided from our head office in Perth, satellite offices in Mirrabooka and Gosnells, within schools and other settings, and through outreach.

Support is provided to people of all ages through individual, family, group, intergenerational, and community development and capacity building services. Our highly skilled staff provide a range of direct services to survivors of torture and trauma their families and communities, which aim to diminish the impact of torture on survivors and enhance their opportunities to rebuild productive and meaningful lives.

Our workforce is small but impactful. ASeTTS' staff are highly experienced in delivering trauma-informed and culturally considered services and show creativity in their ability to adapt to the diverse and varying needs of clients. We employ a range of staff from diverse professional disciplines, including a qualified teacher, youth workers, experienced community development officers, trauma counsellors with qualifications in psychology, mental social workers, psychotherapy, and counselling (all of whom

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[1] Refer to https://www.fasstt.org.au/
[2] Refer to https://irct.org/

are registered with relevant professional bodies). Most staff (75%) hold postgraduate or master's qualifications in their field and engage in ongoing professional development.

We also note that:

- To deliver additional clinical support to clients Consultant Psychiatrist, Dr Susan Lutton, has for 30-years provided psychiatric services to ASeTTS' adult clients and clinical support to our clinicians.
- To connect with clients from different language and cultural groups we work extensively with independent accredited translation and interpreting services, and recruit and train a team of Bi-Cultural Facilitators to strengthen relationship with clients and communities, to work alongside and mobilise communities. Our Bi-Cultural Facilitators come from refugee backgrounds, and many are torture and trauma survivors.

Including our lean administration team and Executive leaders ASeTTS currently employs the equivalent of 29 fulltime staff.

2. Our clients

a. Numbers of people supported

Across its 32-years in operation ASeTTS impact in supporting torture and trauma survivors has been significant. It is estimated that the organisation has provided direct support to over 25,000 people and has indirectly assisted the families and communities around those people. On average the organisation supports over 41% of all newly arrived humanitarian entrants in WA each year (noting there were some changes experienced during the COVID lockdowns[3]).

Demand, and referrals, for ASeTTS' services continues to increase with an 51% rise in client numbers recorded in the 2022-23 financial year compared to the preceding year, and 128% increase from 2020-21. In the 2022-23 financial year over 1,700 clients were supported by ASeTTS.

b. Countries of origin and languages spoken

ASeTTS provides services to clients from a wide range of countries, ethnic and cultural backgrounds, and language groups. Our client demographics vary each year with changing international contexts and conflicts. In recent years we have supported clients from over 91 countries of origin and 70 language groups. Internal data tells us that in FY 2022-23, 71.4% of clients came from a total of nine (9) countries, including:

- Afghanistan (15.4%)
- Iraq (12.2%)
- Australia (9.0%)
- Syria (8.2%)
- Iran (8.0%)
- The Republic of the Union of Myanmar (7.8%)
- Eritrea (4.9%)
- Sri Lanka (3.1%)
- Venezuela (2.8%)

[3] ASeTTS 2022, *PASTT Review 2022: ASeTTS Service Profile – 2016 to 2021*, ASeTTS: Perth, WA.

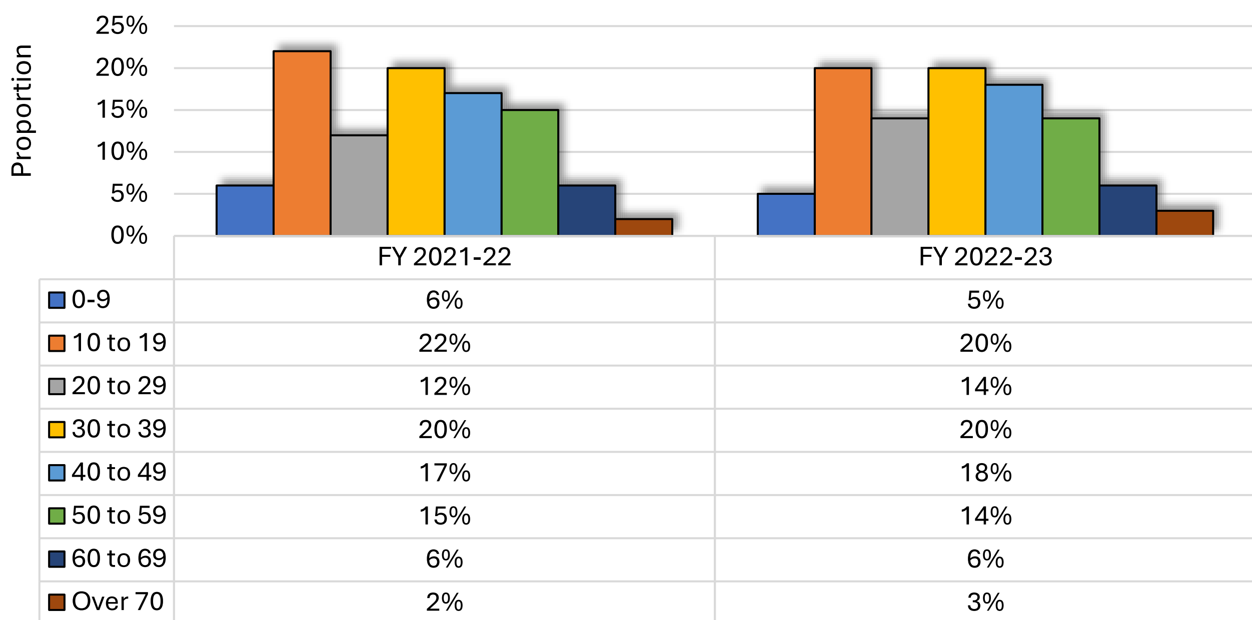
While the top countries were very similar to previous years, FY 2022-23 saw an increase in clients who were born in Australia into refugee families and who are experiencing complex intergenerational trauma. The increase in numbers of Australian born clients is attributed to targeted work that ASeTTS has undertaken alongside the Eritrean community in Perth in response to community calls for support.

To deliver culturally sensitive, safe, and responsive services we work alongside and through independent accredited interpreters; each year between 50% and 70% of our clients require the use of interpreters.

c. Age ranges

While we support people across the lifespan, most referrals received and clients seen by ASeTTS are adult survivors, a quarter of current clients are under 19 years-of-age (refer to Figure 1).

Figure 1. Client age ranges FY 2020-21 compared to FY 2022-23



	FY 2021-22	FY 2022-23
0-9	6%	5%
10 to 19	22%	20%
20 to 29	12%	14%
30 to 39	20%	20%
40 to 49	17%	18%
50 to 59	15%	14%
60 to 69	6%	6%
Over 70	2%	3%

It is noted that the true population of children and young people in Western Australia (WA) who would be eligible for ASeTTS services cannot at this time be accurately quantified. ASeTTS' 2021 research exploring the unmet service needs of children under 12-years-old from refugee backgrounds highlighted a lack of available data from government agencies and from provider organisation's alike and poor interoperability of data from different sources[4].

d. Gender

While in the past ASeTTS' recorded most clients as male (50% and over) in FY 2022-23 women were in the majority (62%). This trend is noted as consistent across the FASSTT Network. For ASeTTS this shift is attributed to an increased number of programs providing targeted support to women (e.g., We

[4] ASeTTS 2021, *Developing services to meet the unmet needs of children under 12 from refugee-like backgrounds who are impacted by torture and trauma. A qualitative exploration of the needs, challenges, and barriers to service delivery within the refugee services sector in WA,* ASeTTS: Perth, WA, available at https://asetts.org.au/lotterywest-project-update/

Women Leading Us, Al-Noor Ellenbrook Project, and Supported Play Group), and the increased proportion of new arrivals being women from Spanish-speaking backgrounds and/or women at risk.

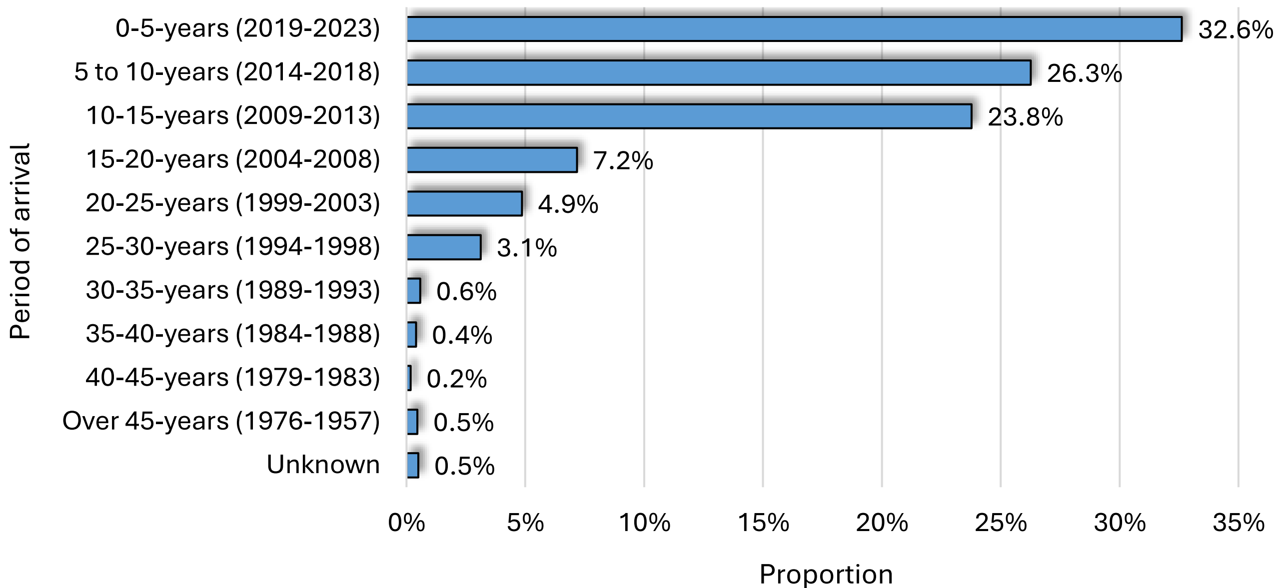
A recent community consultation with men has indicated men may be struggling to participate in activities during standard work hours, and services need to be available on weekends and after hours to accommodate work and other demands.

In recent years there has been a gradual increase in the numbers of clients who identify as non-binary or transgender.

e. Average time in Australia before accessing torture and trauma recovery services

While most ASeTTS' clients in FY 2022-23 arrived in Australia in the past 5-years (32.6%), another 50% have arrived in the past 5-15-years. One client first arrived in Australia in 1957.

Figure 2. FY 2022-23 client period of arrival in Australia



f. Length of time accessing services

On average between 50-60% of clients have accessed services for a period of more than 1-year, this is not unusual for torture and trauma rehabilitation services as there is recognition that recovery from torture and trauma requires long-term engagement and support. In addition, ASeTTS' funding arrangements support continued engagement with services, rather than a maximum number of sessions per/calendar year as is available under Medicare rebates and government funded community mental health services.

g. Torture and trauma experiences

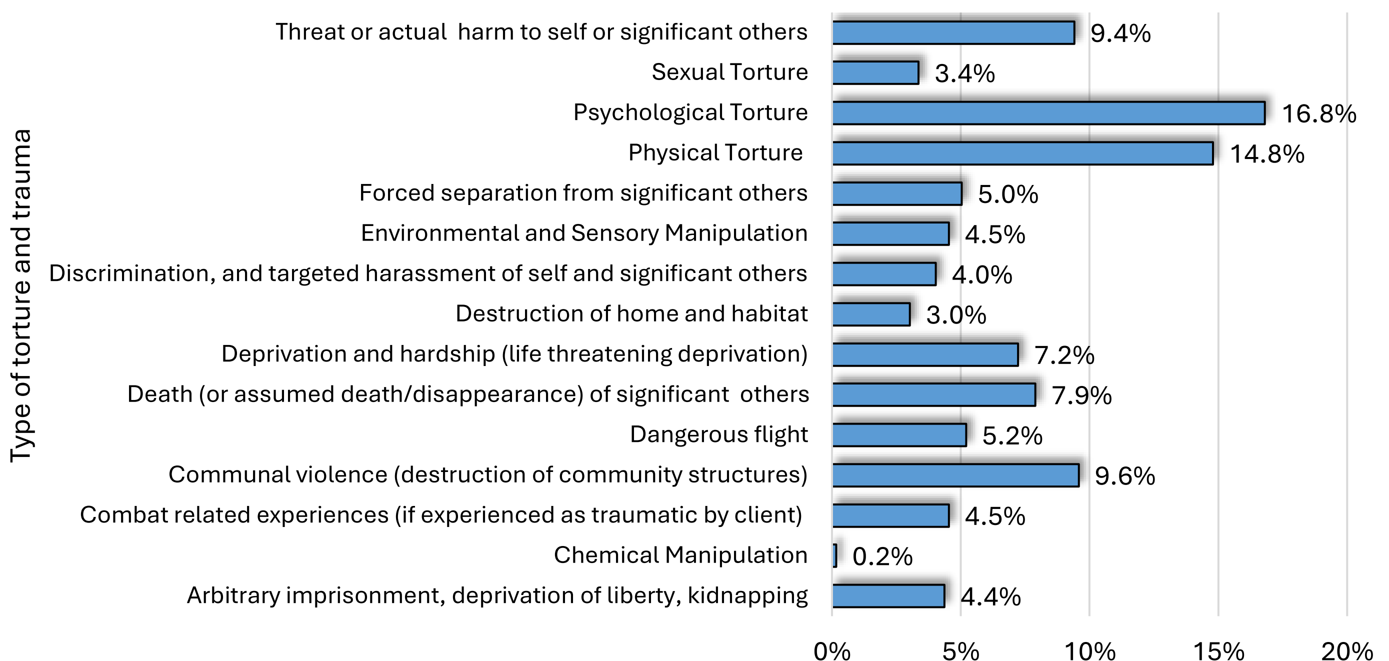
ASeTTS' clients have diverse experiences of torture and trauma. While some clients are not comfortable to disclose their experiences even after years of accessing supports, our analysis of client reports of torture and trauma experiences indicates that of those who do report their experiences, up to 16.8% have experienced psychological torture. This is followed by physical torture (14.6%), communal violence (9.8%), and threat or actual harm to self or others (9.4%). This is illustrated in Figure 3.

The people we support often experience multilayered complex post-traumatic stress disorder (C-PTSD). Along with having prior experiences of torture and trauma that many people would struggle to comprehend, a significant proportion of our clients (both adults and children) face challenges in their transition to life in a new country and many are impacted by Visa insecurities, and lengthy separation from family members and significant others. We note that unresolved trauma, language barriers and limited knowledge of Australian culture, systems, laws, and expectations often impedes access to the services needed to address settlement, health and wellbeing, education, and vocational needs of people from refugee-like backgrounds.

It is further noted that a significant proportion of the people and families we support also face additional challenges in their daily lives which exacerbate their trauma symptomology and complicate their recovery pathways. A review of complexity of client needs has for example identified that more than half of ASeTTS clients have significant concerns for family members who remain overseas in tenuous political environments or areas of armed conflict (53%). Other measures include[5]:

- interface with multiple services (48%),
- multiple family members accessing torture and trauma recovery services (34%),
- imminent risk of destitution (32%),
- active suicide ideation (28%)
- family and domestic violence (FDV) (24%),
- immediate risk of homelessness (22%),
- child safety concerns (17%), and
- self-harming behaviours (15%).

Figure 3. Types of torture and trauma experienced by clients in FY 2022-23[6]



[5] ASeTTS 2021, *Client Complexity Snapshot Data for 18 August 2021,* ASeTTS: Perth, WA,
[6] ASeTTS 2023, *National Minimum Data Set (NMDS) Stage 3 Report,* ASeTTS: Perth, WA,

Children, young people, and families who are asylum seekers carry additional burdens due to their rights not being recognised, lack of work rights, having limited access to much needed services, fear of authority, and carrying a deep sense of hopelessness for the future. ASeTTS' clinicians can find it extremely difficult to support the torture and trauma recovery, mental health and wellbeing needs of asylum seekers under the shadow of hopelessness. We often see our role as holding people as they manage ongoing trauma.

Our western systems are difficult to navigate, and clients often require extensive support to understand their service needs, their rights to services, and how to access relevant services. Due to their trauma experiences our clients do not easily trust unfamiliar people, and typically rely on people, organisations, and workers that they know and who have proven themselves to be allies to navigate service systems. Our employees often act as system translators, navigators, and advocates to connect clients to the different services they require, and to ensure their continued access to services.

Even before ASeTTS' engages clients in personalised mental health services, there is considerable time invested in developing relationship and rapport with the client, with a view to restoring safety, and building trust. This 'pre-counselling' phase can involve our providing light touch supports, connection through community-based activities, and warm referrals to other providers to assist the client with addressing immediate physiological needs.

Case Study 1. Exploring the needs of Naila, an asylum seeker from Pakistan.

Naila[7] is an 18-year-old woman from Pakistan who arrived in Australia 10 years ago seeking asylum with her mother, grandparents, and siblings. The family arrived in Australia by boat and have reported her family have had difficulty settling into life in Australia. Naila self-referred for ASeTTS services.

At time of referral Naila had withdrawn from her university studies due to feeling overwhelmed, and reported feeling worthless, ashamed, and dismissive of her feelings and no longer having a hope for the future. Intake assessment highlighted that:

- Naila has faced considerable bullying in school,
- She has experienced anxiety and depression for many years and engaged in regular self-harming behaviour.
- She struggles with her mental health needs and feels guilty that she needs additional support.
- Due to her family's asylum seeker status, Naila (and her family) live with the constant anxiety associated with visa insecurity.
- Additionally, Naila and her family have limited access to practical support services because of their asylum seeker status.

Based on her assessment and identified needs Naila was promptly engaged in counselling services and was also referred to ASeTTS' Consultant psychiatrist for further assessment and pharmacological support. To ensure Naila could return to her university studies in the future advocacy support was provided to liaise with the university and retrospectively withdraw from her course.

When Naila experienced a peak in her symptoms and was presenting as an immediate risk, she required admission to hospital for full risk assessment and inpatient mental health treatment. The

[7] Pseudonym used.

delay in the family's Medicare status being renewed meant that they did not have current Medicare status when she required immediate admission. It was only due to the generosity of a church organisation that had previously supported Naila's family, that her hospital costs could be covered.

As a result of the supports provided by ASeTTS' counselling and consultant psychiatrist Naila is now experiencing more stable mental health. She is well supported by ASeTTS and accesses appropriate pharmacotherapy. Naila is resuming university in 2024 and looking forward to a positive future.

Despite being more stable, Naila has a long history of struggles with her mental health and as such is expected to require consistent counselling support and risk assessment. Overall, as Naila and her family are still considered asylum seekers and their visa status remains uncertain, their anxieties and insecurities will continue. Until they have greater certainty and sense of stability, their stress will remain high and mental health will be impacted.

3. The impact of torture and trauma on children and young people

The impact of torture and trauma on families and children cannot be downplayed. A recent internal review of services has identified varying trauma presentations and mental health needs for children and young people. Children and young people who present, or are referred, to our services may have direct experiences of torture and trauma, or may live under the burden of their parents, siblings, or family members torture and trauma experiences. Regardless of whether experiences are direct or indirect (e.g., intergenerational trauma), we note that children and young people under 18-years often experience disorganised and inconsistent engagement with their parents or caregivers.

Parents who have themselves experienced torture and trauma struggle to support and engage their children while addressing their own sometimes complex healing and recovery needs and managing the challenges of transitioning to life in a new country. This has palpable impact on the socio-emotional development, and longer-term mental health and wellbeing of children and young people we support. Our 2021 research[4] identified that where trauma impacts refugee families it can result in:

- *Power shifts in family relationships*
  For example, shift in gender dynamics and role expectations between parents. In addition, power dynamics between children and parents can shift. This is particularly the case where children have greater knowledge and proficiency of English, and parents rely on the child to communicate with others.

- *Complexities around acculturation and cultural identity*
  The tension of being between cultures creates conflict between parents and children. For example, refugee children often feel conflicted about adapting to the Australian culture and holding onto their family's culture and customs and feel caught between the two cultures. While parents' express concerns about children losing their cultural values and beliefs and assimilating to Australian culture.

- *Impacted school performance*
  The more distressed a child or young person is the more their progress in school is impeded.

It is an ongoing challenge engaging families and caregivers in treatment access, planning and delivery for the children and adolescents we support. This is not surprising considering many families and caregivers are fearful that accessing parenting supports or services to assist their children, will lead to them being 'sent back', parenting intervention by child protection authorities or to negative outcomes in Visa and Citizenship processes.

In addition, concepts of mental health, treatment, planning and reviews do not comfortably translate for many of the cultural and language groups we support. We strive to be culturally sensitive to what mental health means to our clients; and are mindful that being labelled as a mental health provider reduces both the accessibility of our services, and the level of trust people from refugee-like backgrounds, their families, and communities have in ASeTTS' services. Mental illness remains highly stigmatised in CaLD communities, and many of our clients would not access mental health, counselling or psychiatric services in their own culture or communities. To engage clients, we do not promote ourselves as a mental health provider. Instead, we make every effort to be seen as a safe place where people are heard, and their wellbeing is supported.

Other barriers to service access are noted[3], these include:

- Language barriers,
- Limited understanding of service systems and access pathways,
- Mistrust of service providers and interpreters, and
- Lack of available transport, or reliance on public transport, to get to appointments.

Even as a trusted provider within the CaLD community, families and caregivers rarely proactively seek out our counselling services for children and young people. We rely on external service providers, GPs, educators, the Australian Red Cross Humanitarian Settlement Program (HSP) team, and Health Department teams and specialist teams (e.g., Perth Children's Hospital Refugee Health Clinic) to make referrals for children and young people from refugee-like backgrounds. In addition, our clinicians often refer children and young people to internal services after treating their family members and identifying specific issues needs within a family.

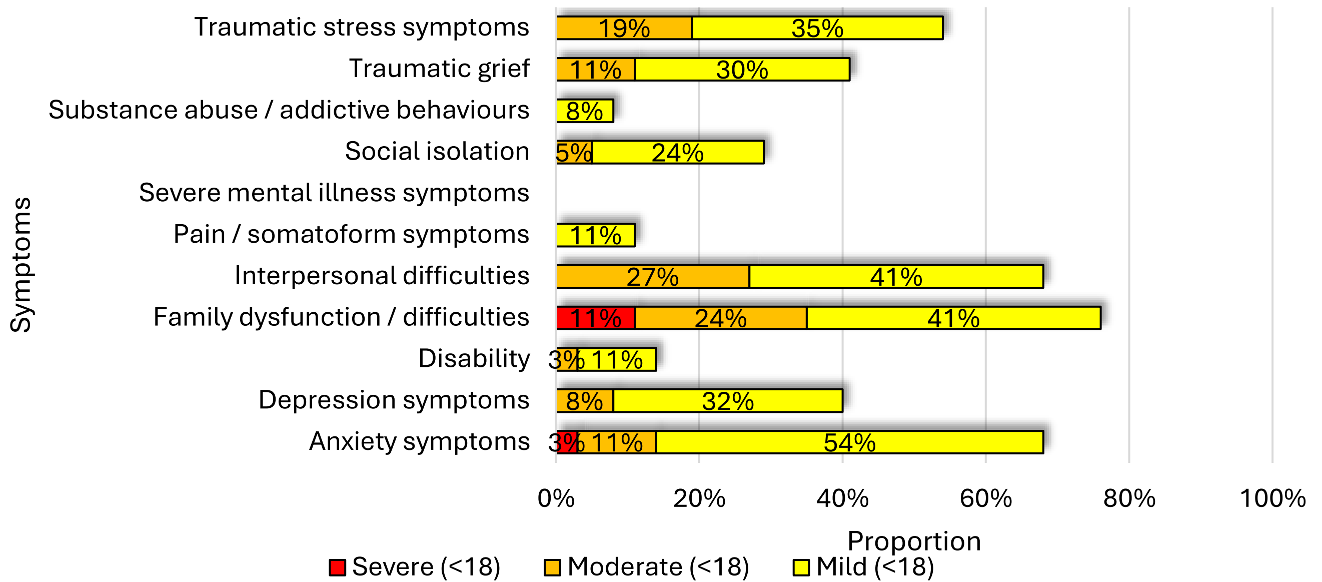
While the referrals we receive for children and young people often outline concerns about school non-attendance or refusal, or community support needs; after a period of working with the child or young person our clinicians and youth workers typically identify a complex web of unmet psychosocial needs and unresolved traumas.

ASeTTS' staff report that the mental health needs of the children and young people we support has become increasingly complex in recent years (refer to Figure 4). Case review has identified that clients who are between 12 and 18-years-of-age often experience, or are reported to experience:

- instability in their homes,
- developmental and cognitive delays,
- avoidant or disorganised attachments
- aggressive and antisocial behaviours,
- eating disorders,
- risk of homelessness or street presence,
- unhealthy interpersonal relationships and FDV, and
- in some cases, young people present with serious psychiatric illness.

For children under 12 years-of-age, autistic traits, emotional dysregulation, and developmental delays are commonly observed.

Figure 4. Presenting symptoms in clients under 18-years-of-age FY 2022-23[3]



External referrers, particularly those from public mental services, do not always appreciate the time that is required to deliver person-centred, culturally safe service. They can be highly critical of the methods used to support children and young people to address the various layers of trauma, and at times encourage the young person or family to seek alternative supports.

Some external referrers will focus on specific transactional measures when assessing the effectiveness of services and overlook the value in providing services that address the holistic needs of clients. For example, one external referrer has raised concerns that, despite lengthy engagement with ASeTTS' clinicians a young person's school attendance had not improved. Improvements in the young person's wellbeing and interpersonal relationships were not considered as important as regular school attendance. This highlights a difference in priorities between parties, ASeTTS' focus remains on improving our client's wellbeing.

To understand the needs of the young people we support in counselling (noting that some clients engage in group programs only) ASeTTS clinicians work with children and young people and their families/Guardians (as appropriate) to:

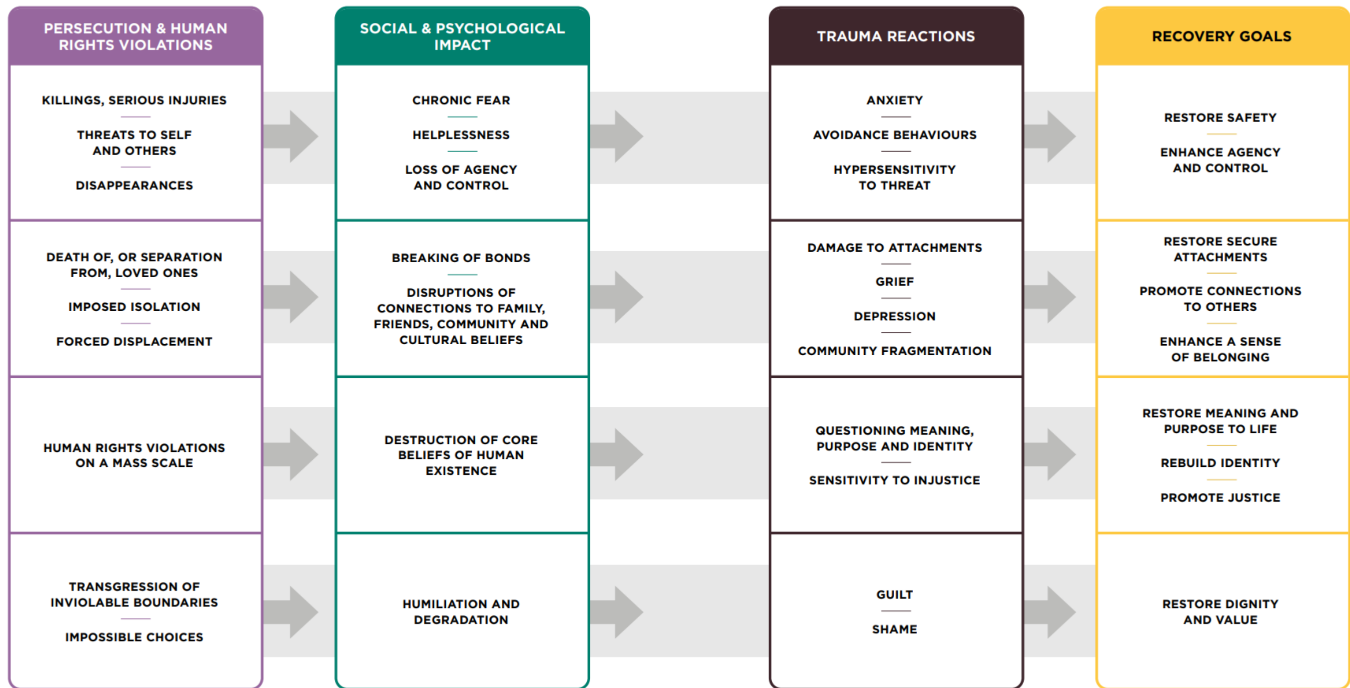
- Understand immediate presenting needs through intake assessment.
- Complete more comprehensive assessments of symptoms and experiences, using tools that are considered reliable and are validated for use with culturally diverse populations. Tools include:
    - *Hopkins Symptom Checklist*
      The checklist can be used for individuals over 13-years-of-age, it is an inventory which measures symptoms of anxiety and depression.
    - *Strengths and Difficulties Questionnaire (SDQ)*
      The SDQ is a brief measure of behavioural and emotional difficulties that can be used to assess mental health problems in children and young people aged 4–17 years.

  - *WHO-5*
    The World Health Organisation- Five Well-Being Index (WHO-5) is a short self-reported measure of current mental wellbeing which has been translated into more than 30 languages.
- Develop treatment plans with identified therapeutic and psychosocial goals.
- Regularly review progress against the treatment plan and assess symptoms of anxiety and depression as well as their overall wellbeing using the previously mentioned tools.

While these processes are enshrined in the organisation's policies and in sector standards and expectations, to deliver effective services ASeTTS' clinicians are required to respond in a flexible and sensitive way to the needs of individuals being supported. It is our experience that it can take time to establish safety for clients that have experienced torture and trauma and build sufficient trust to engage in treatment planning and goal setting. Restoring safety is a critical part of the recovery process for our clients, and in applying the VFST Trauma Recovery Framework, is considered a standalone recovery goal (refer to Figure 5).

While ASeTTS' clinicians and youth workers aim to address the various issues impacting the children and youth in our services, the complexity of clinical needs is sometimes outside our expertise. For example, where it is suspected that a child or young person is experiencing severe mental illness ASeTTS' clinicians are encouraged to seek external public mental health supports for their client and support the young person and their family to access these services. It is noted that, despite 30-years of delivering services to clients and clinical governance support to clinicians, ASeTTS' Consultant Psychiatrist, Dr Lutton, is not a Child and Adolescent Psychiatrist. Our staff confer with Dr Lutton to explore the needs of children and young people in our care and identify assessment needs and external support options. In many cases it is difficult identifying suitable and affordable services, and public mental health providers tend to reject our referrals for additional clinical mental health or psychiatric input for our clients. This issue is addressed further in the next section.

Figure 5. Trauma Recovery Framework[8]



Case Study 2. Maryam[7], a traumatised young person in a family impacted by refugee torture and trauma.

Maryam is a 14-year-old girl who currently accesses ASeTTS' youth counselling services, Maryam hopes to become a doctor when she is older.

Maryam and her family are well known to ASeTTS. Maryam has previously accessed services when she was 7 years old when her family were newly arrived to Australia. Her parents also attend individual counselling, and her older brother (15) is linked to Youth Support. Maryam's family are originally from Afghanistan but fled to Iran where they lived for several years before arriving to Australia 8-years-ago. Maryam was born in Iran, where they lived without documentation, limiting their family's access to employment and education. Maryam's parents both have their own individual experiences of torture and trauma in Afghanistan.

The difficult living situation faced by Maryam's parents during her first 5 years is likely to have meant that she did not receive the appropriate connection and attachment bonds required for optimal brain development. This has resulted in a presentation of developmental trauma and Maryam having intense experiences of fear, anxiety, and difficulties with impulse control. Maryam's fear and anxiety is often triggered by stressors in her life. She has stated that she sometimes hears voices, and that they tell her bad things about herself, for example that she is not good enough and that no one loves her or cares for her. Maryam also experiences nightmares, intrusive thoughts and difficulty engaging in school. She becomes fearful at night and needs a parent to sleep in her bedroom with her. Her fear and anxiety are

[8] Kaplan, I 2020, *Rebuilding Shattered Lives,* 2nd ed, The Victorian Foundation for Survivors of Torture (VFST) Inc.: Brunswick, Vic.

impacting her school performance, and this in turn reinforces her intrusive feeling of not being good enough as she wants to become a doctor when she is older.

Maryam's parents have individual trauma histories that Maryam is unaware of. Her father lost family members in acts of violence that he was witness to. As a result of his trauma, he also hears voices and struggles with the impact of complex PTSD following these events. Maryam's mother also struggles with the impact of her past exposure to traumatic events in Afghanistan, particularly related to the loss of family members. She often presents as extremely dysregulated with socially inappropriate behaviours.

Maryam's parents have limited capacity to understand the challenges faced by their children or reflect on the impact their own traumas have on their family. Maryam and her brother are impacted by intergenerational trauma. They may not have had exposure to the initial trauma, but due to the impacts that their parents face they are unable to parent at their full capacity. As a result, the entire family continues to deal with the impact of the initial trauma even several years later.

Both parents have had limited schooling and very minimal English language ability (e.g., they both cannot read and write in English), and have struggled to understand how Australian systems and services operate. It is likely that due to the cognitive impact of trauma, Maryam's parents are unable to learn English to be able to navigate systems independently. Maryam is often required to act as her parent's interpreter and the family advocate due to her English proficiency, this includes through the process of her older brother's recent diagnosis of autism and ADHD, and his brief incarceration and release (now awaiting judicial outcome).

There have also been indicators of Family Domestic Violence (FDV) in the home; where all members of the family appear to perpetrate physical violence when they enter disagreement with each other and become dysregulated, and simultaneously falling victim to physical and verbal aggressions in the home. While many counselling sessions have been facilitated to address the FDV cycle within the family, the family typically deny there is an issue and end discussions. As a result of concerns about the family, formal reports have been made to the Department of Communities: Child Protection, all have been closed shortly following submission.

Several parent sessions have been had to discuss the parenting challenges that are faced in the home. Maryam's parents struggle with everyday issues such as (but not limited to) managing screen use and allocation of chores within the household. While reliance on Maryam to act on the family's behalf in medical or service settings has assisted the parents in the short term, it has created a power imbalance within the household. For example, Maryam holds a view that she does not need to follow boundaries set by her parents and will often leverage the power she holds or threaten her parents to have her needs met. This creates fear for the parents who give in to her demands and lose their ability to set appropriate parenting boundaries.

"…if my phone is taken at night, I will scream until the neighbours complain and the police will come, you (the parents) will get into trouble."

Despite the various challenges Maryam has benefitted from the supports she has received from ASeTTS. Her parents look forward to ASeTTS programs as they believe that this is a positive space for

their children, and they trust ASeTTS' staff. Both parents have found it challenging to find other programs and activities that they are comfortable sending their children to without their presence.

Various supports have assisted Maryam. Through accessing ASeTTS' youth holiday activity program and camps over a 2-year period, Maryam's confidence has grown as has her circle of supportive peers. While continued engagement in individual counselling has provided Maryam a space to explore topics of self-worth and trauma impacts. She gains comfort in talking about aspects of her family life that she is beginning to understand as not functional, for example, resorting to violence when upset. Maryam also uses sessions to explore personal goals (e.g., such as improving her grades) and her Counsellor provides support for accountability in the absence of her parents being able to provide this to her. Outside our services Maryam has found part time employment after school which has assisted her to develop greater independence and responsibility.

Maryam's parents regularly attend parent sessions where they discuss parenting difficulties and are supported to develop strategies that they can then implement at home. While this process is slow, they show a deep commitment to supporting their children and improving their daughter's wellbeing.

4. ASeTTS' services for children and young people

ASeTTS provides a range of services to children and young people. It is noted that programs and initiatives delivered change depending on the needs and interests of the children and young people we support and their families.

Table 1. ASeTTS services to children and young people as at 1 January 2024

Service	Description
Trauma Counselling	• Counselling provided to the individual and/or family to assist in processing trauma and managing symptoms that occur in daily life. • Support is provided on location at ASeTTS' offices, through outreach in primary or high school settings. • Different modalities of service are delivered including narrative approaches and play therapy. • Our counselling approach is focused on long-term engagement with clients.
Youth Work	• Support to a young person to facilitate their personal, social, emotional, and educational development. • Youth work often works alongside counselling services.
School holiday programs and youth camps	• Activities are delivered by counsellors, youth workers and Bi-Cultural Facilitators. • Activities are based on the Circle of Courage Model, a model of positive youth development based on the principle of universal needs for emotionally healthy youth including a sense of belonging, mastery, independence, and generosity. This approach supports young people to form connections, establish safety, and appreciate their strengths and gifts[9].

[9] Woods, L.K 2021, *'Implementing the Circle of Courage Framework to develop my trauma-informed practice: A self-study'*, Vancouver Island University, available at https://www.viurrspace.ca/

Service	Description
Children in Cultural Transition Program (CICT)	• Tailored program to support primary school aged children who are newly arrived in transitioning to schooling and life in Australia. • The program provides children information and support on settlement, the school system in Australian, discrimination and bullying, family, friendships, and social connections, and belonging and safety. • Delivered by ASeTTS' for over a decade.
Warriors of our Wellbeing (WOW) Program	• A group therapy program delivered by ASeTTS' counsellors and education officer within Intensive English Centres (IECs) or in partnership with IECs. • Program supports students to explore themes of self-identity, personal strengths, cultural identity and pride, self-esteem, sleep hygiene, healthy habits, mindfulness, and emotions and emotional regulation. • This is relatively new program that was developed in collaboration with students, caregivers and educators at Koondoola Primary School and is loosely based on the previously implemented Rainbow Program.
Expressive Art Therapy Program	• Expressive activities to support clients to: ○ express feelings that are challenging to voice, ○ develop healthy coping and self-care skills, ○ develop creativity, ○ reduce isolation and develop supportive social networks, ○ prepare for transitions from primary to high school and high school to adulthood.
Parenting Support Programs	• Bespoke programs that are delivered in partnership with other providers to support mothers of children under 6-years with support in their parenting role. Examples include supported therapeutic play group and Sing and Grow programs.
Other resources	• ASeTTS in partnership with FASSTT sister agencies also develops other resources to assist schools, parents and other community members in supporting traumatised children and young people from refugee-like backgrounds. An example is found in the Appendix.

**Please note:*

- *All programs undergo review and evaluation.*
- *Where the client is a child, informed consent will be given by the child's parent or guardian; along with the child (if possible). If the child is a mature minor (16 and above) they are assumed to have sufficient intellectual and emotional maturity and competence to provide informed consent.*

We recognise that we provide limited supports for children under the age of 12, and have identified the need for:

- ongoing tailored parenting education supports,
- health and mental health education, promotion, and prevention programmes – including resources and videos in language,
- specialist child and adolescent psychiatric and clinical developmental psychological support,
- services delivered within local communities in community hubs (e.g., schools),

- services to better consider the settlement demands of families and caregivers (e.g., scheduling programmes and supports at times when AMEP English lessons are not being delivered),
- trauma-informed play groups and social groups that accommodate and include children from different age groups,
- delivering long-term group or individual counselling to children and young people – moving away from school holiday programs and short-term intervention supports,
- services to always be co-designed with children, young people, and families, and
- services to be delivered in partnership with other specialist providers, to leverages the skills and expertise of different professionals to deliver positive outcomes.

ASeTTS is limited in what we can reasonably implement long-term without additional resources.

Case Study 3. Warriors of our Wellbeing (WOW) Program.

ASeTTS' 2021 research exploring services available to children under 12 from refugee-like backgrounds impacted by trauma identified opportunities for service development to better respond to client needs. This included programs and initiatives that could be delivered in the short-, medium- and longer-term[4]. The stakeholders we consulted identified the need for in-school group therapy programs for primary school aged children.

To develop the new service, ASeTTS facilitated consultations in early-2022 with interested partners Koondoola Primary School IEC and Edmund Rice Centre. Together we explored preferred program structure and content, management and referrals to groups, and logistics relating to timing of groups within the school daily schedule. Further consultations were held with:

- School educators to explore key issues in supporting students from refugee-like backgrounds in the classroom.
- Parents and families to gather information about their hopes and expectations for the group.
- Students to identify group objectives and themes.

Consultations were well-attended, and feedback assisted to shape the content of the program. The WOW program was the result.

The WOW program is an adaptation of the Rainbow Program that is delivered by FASSTT sister agency Foundation House in Victoria. The main aim of the program is to make a positive contribution to the settlement experiences of children from refugee backgrounds through therapeutic group activities focusing on, but not limited to, attachment, adjustment, identity, self-esteem, identifying personal strengths, and emotional regulation. Examples of activities that have been developed for the program include:

- Cultural identity and belonging: 'All about me' poster, 'Tree of Life', 'Journey to Australia' group mapping activity, using clay to create a pendant symbolising their culture and/or identity.
- Self-esteem: mask making, self-identity collage activity, 'hero quest' activity.
- Emotions: drumbeat, meditation, breathing games and exercises, regulating parachute activities and games such as 'sleeping ninjas'.
- Healthy relationships and friendships: drumbeat, team games, providing students with ownership over decision making for the group and having to work together to make choices.

WOW is delivered on a weekly basis within a school term for a minimum of two terms per 8-week group (i.e., on average of 16 group sessions in total). Participants are primary school children from refugee-like backgrounds of mixed genders and diverse language groups. Since 2022, WOW has been delivered in three different IECs. Each program adapts to suit the needs of the new school and student cohort. Before each program consultation occurs with educators, parents and students to fine tune goals, expectations, and course content. Similarly, post-program evaluation with educators, parents and students provides rich information about the impact of sessions and opportunities to further strengthen the program.

Feedback provided by parents has included:

- A parent noted a significant improvement in their child's confidence, respect, and ability to take responsibility. They noted the importance of ensuring their child's growing and learning continues.
- A parent spoke about the confidence her son had developed, and that he was then able to use this confidence to develop more friendships in school. As he is changing schools next year, his parents are happy that he can not only be caring, but also feel confident to build relationships.
- Another parent commented that she noticed her son is a lot calmer. He would previously struggle to sit still.
- A mum expressed that because of the program all 3 of her children were now linked to ASeTTS, and asked if there were programs or services for her other children.
- One dad stated that his daughter was able to verbalise and express how she felt a lot better and was less frustrated at home.

5. Access to public and community mental health services

ASeTTS' staff consistently report difficulties in securing public and external community mental health services for our younger clients (e.g., CAMHS and headspace). In fairness we recognise the resourcing issues that public, and community mental health providers are experiencing (as we too face this challenge) and understand that resourcing problems impact their ability to accept new referrals, to take time to assess and understand client needs, or to collaborate with ASeTTS' staff to provide shared care support to children and young people from refugee-like backgrounds.

a. Public mental health services

Where public mental health services have engaged our clients, clients and/or their family members have raised concerns with us that their safety and cultural needs have not been sufficiently considered. Clients and their family members have reported that:

- contact was very brief,
- assessments were undertaken in a rapid burst with limited support to understand questions asked (and sometimes no consideration of English proficiency),
- the environment was unwelcoming and clinical and some cases felt like rooms in detention centres, and
- they have not felt safe or understood and have gotten through the assessment as quickly as possible to leave the space.

Such environments create mistrust and obstruct open and safe discussions about the individual's needs, state, and experiences. This has led to what we believe are inaccurate assessments of the needs of our most complex clients. We have various examples of clients we have referred for services

being assessed as having low needs and of low priority for services. In some cases, individuals are re-referred to ASeTTS for trauma counselling, in other cases there is little or no follow up.

In the absence of services ASeTTS make every effort to respond and fill the gaps in the system to ensure children and young people access some supports, however our resourcing and staffing constraints and our clinical capabilities limit our ability to cover all needs. ASeTTS does not have the required levels of funding to employ the number of trauma counsellors needs to reasonably meet demand; let alone employ Clinical Psychologists or engage a Consultant Child and Adolescent Psychiatrist for more complex cases.

Case Study 4. Saad's[7] challenges accessing public mental health services.

Saad is a 4-year-old boy from Gaza who was referred to ASeTTS by his father. He arrived in Perth 3 months ago shortly after the war in Gaza began. Saad and his family fled the Gaza area via the Egyptian border. Saad and his father are Australian citizens, his mother and younger sister (18 months) arrived on tourist visas.

Saad's father made the referral as he held concerns that, at 4 years-of-age, Saad could not talk and seemed to avoid social settings. He was reported as spending most of his time in front of a TV screen and had difficulty regulating his emotions. While Saad's presentation was reported as consistent since he was a baby, his father noted that after the Gaza war began, Saad has become increasingly fearful and covered his ears every time he heard a plane flying overhead.

A home visit had to be conducted to further assess, as Saad's mother has no car and no understanding of the WA public transport system. Due to being on a tourist visa, mum is not eligible for settlement support services, and cannot be referred to agencies that provide this support.

During assessment mum's concerns about Saad mirrored dads. She held concerns that her son was unable to talk and may be behind on developmental milestones. During the meeting Saad's mother outlined that:

- Saad was born in the United Arab Emirates (UAE).
- His family moved back to Gaza (where mum is originally from) to have Saad's developmental needs assessed and access treatment support.
- Tests in Gaza were inconclusive, and as such no treatment was provided to Saad.
- When Saad played with his cousins, his speech started to develop, and he began to learn how to interact with other children. However, once the war broke, they noticed that he became increasingly fearful, and all progress was lost once again.

On assessment, it was noted that the family had no access to other housing supports and were independently trying to secure a private rental. The family lived in the lounge room in a share house.

To avoid disturbing other occupants, Saad and his sister were not allowed to leave their living space. This has resulted in Saad spending significant time in front of a TV or computer screen during the day, until his father returns from work and can accompany Saad, his sister and mother out to the park or for a walk. Saad's mother remains fearful of leaving the house by herself as she is unfamiliar with the country and does not feel confident in her language ability.

During assessment Saad made no eye contact at all with ASeTTS' Counsellor, and when interacting, kept a physical distance. He was glued to the screen and his play was repetitive. At times, he would simply pace the span of the room. It became evident that despite a recent trauma history, there appeared to be other potential for neurodiversity, and that a thorough assessment would be needed first before engaging in any form of counselling, or therapeutic play. On discussion, Saad's mother expressed a preference for comprehensive assessment of her son's needs; stating that most of her concern is for her son. Despite her current trauma and worry for family members overseas, if Saad was assessed and treated, she would also feel more at ease.

A referral was completed for the Child Development Centre (CDC) and Refugee Health Clinic. Whilst there are no strict criteria for referrals CDC does require permanent residence and Refugee Health Clinic typically requires families to be on a refugee visa and be within their first 5-years of settlement. An explanation of client's residence was provided with the referral and at the time of preparing this submission ASeTTS are still awaiting an outcome of both referrals.

As a result of the meetings had with Saad's mother, she referred herself to ASeTTS for counselling support. It is anticipated that part of the support she receives from ASeTTS will involve Saad. This approach will ensure ASeTTS can support Saad's mother through the process of his being assessed. Once thorough assessment of Saad's needs is undertaken, it is anticipated that ASeTTS will be able to tailor trauma counselling services to suit his needs.

b. Community mental health services

While representatives of the Office of Multicultural Interests (OMI) and the WA Department of Health have in 2023 clarified that people from refugee and asylum seeker backgrounds are eligible for community mental health services, we understand that children and young people from these backgrounds are disinclined to access these services.

Based on our knowledge and experience we attribute lack of engagement to:

- poor understanding of services that are available in the community,
- difficulties navigating the community mental health service sector,
- services being focused on the needs of specific cohorts only (young adults and adults),
- providers having inflexible approaches to service delivery (e.g., services delivered at specific locations that are difficult to reach by public transport),
- stigmas associated with mental health service access,
- lack of perceived cultural safety, and
- long waitlists for services.

The families we support have expressed frustration at being required to move between organisations to identify services that might be relevant to their needs or relying on word of mouth. Being pushed between systems and providers does little to facilitate torture and trauma and/or mental health recovery. ASeTTS staff often perform advocacy and casework type tasks with or on behalf of our clients to prevent clients and their families carrying additional trauma loads relating to the challenges of navigating complex service systems and processes. This creates additional responsibilities for our staff but does go some way to preventing our client's experiencing additional trauma because of system navigation (i.e., systemic trauma).

Separately, we have concerns that many 'mainstream' providers lack understanding of refugee trauma, traumas related to war and persecution, or the experience of transitioning to life in a new country. Without this understanding services will struggle to identify the significant etiological factors that have shaped a client's presentation (e.g., predisposing, precipitating, perpetuating, and protective factors[10]). This will reduce the likelihood of meaningful therapeutic interventions being developed for the individual and reduce the providers ability to anticipate challenges that may occur during the provision of services. Our concern is that unless external community mental health providers develop their understanding of refugee trauma that individuals from refugee-like backgrounds seeking services will become unintentionally triggered or retraumatised. While a government agency has suggested that ASeTTS' provide pro-bono training and development to public and community mental health services to improve their capacity to work with people from refugee-like backgrounds, this is an unreasonable suggestion. ASeTTS does not have the resources to meet current service demand, let alone move staff away from service delivery to train external parties at no cost.

It is our recommendation that providers who specialise in supporting children and young people from culturally and linguistically diverse (CaLD) and refugee-like backgrounds (including ASeTTS) are best placed to provide mental health services and other developmental services to this cohort. To increase the scope of services available, organisations require increased resourcing. Services are currently underfunded, often funded for short timeframes only, and as a result can support only small numbers of children and young people.

Finally, while services tailored to children and young people from CaLD and refugee-like backgrounds are limited across the board, there are very few services for CaLD and refugee children under 12 years-of-age outside of the school system. The lack of services, and capacity to develop and deliver services is deeply concerning, particularly as schools are neither equipped nor resourced to meet all health, mental health and wellbeing needs of the community.

Case Study 5. Assisting a young person to navigate complex systems.

Anaya[7] is a 14-year-old girl, who was born in Australia to parents who met in a refugee camp. Mum is from Sri Lanka and Dad is from Somalia. She was referred to ASeTTS by Department of Communities: Child Protection, due to reports of being harmed and neglected by parents. Anaya's parents lacked insight towards their daughter's health and mental health needs. Anaya was reported as experiencing anxiety and depression; however, her parents had not linked her into any supports or medical professionals.

[10] *Predisposing factors*. This includes possible biological contributors, genetic vulnerabilities (e.g., family), environmental factors (e.g., socio-economic status, trauma, or attachment history) and psychological or personality factors which may put a person at risk of developing a specific mental health difficulty.

Precipitating factors. This can include significant events preceding the onset of mental ill health, such as substance use, or interpersonal, legal, occupational, physical, or financial stressors.

Perpetuating factors. This includes factors which maintain the current difficulties. These can include ongoing substance use, repeating behavioral patterns, biological patterns, or cognitive patterns such as attentional biases, memory biases, or hypervigilance.

Protective/positive factors. This includes strengths or supports that may mitigate the impact of mental ill health.

Anaya's initial assessment with ASeTTS identified that she had managed primary school education relatively well, however once she began to attend high school, she reports feeling panicked, under pressure and stressed. These feelings became overwhelming for her, and she began attending school very infrequently. By the time Anaya was referred to ASeTTS she had not attended school for over a year. Anaya requested ASeTTS' support to re-engage in education but experienced very high anxiety at the thought of returning to school. She had also become increasingly socially isolated since leaving school and had no social support. Her daily routine was simply remaining at home and watching TV or sleeping.

She developed an eating disorder due to her perception that she was overweight and that her social isolation was the result of peers thinking she was ugly and fat. There also was concern about other cognitions this young woman disclosed, which were potential indicators of disordered thought patterns which could indicate early development of a more serious mental health condition. It was considered important to have further assessment of Anaya's mental health and support needs in the context of a family history of PTSD and delusional disorder.

Actions taken:

- *Referral to CAMHS*
  A referral was made to CAMHS for assistance. The referral to CAMHS was not accepted and the response was that the indications of a formal mental health diagnosis were not strong enough to warrant further assessment from them. The rejection of the referral to CAMHS indicates that CAMHS are under pressure with many referrals and need to prioritise only the most severe cases. There is little scope for early assessment and intervention support.

  The ASeTTS' Counsellor has requested that the Department of Communities: Child Protection advocate for Anaya to access CAMHS support.

- *Identifying alternative education*
  Anaya's ASeTTS' Counsellor began advocacy around education and facilitated meetings with the school regarding Anaya's in-school support needs. With Anaya still expressing high anxiety and unable to attend school meetings, school representatives suggested that it was the Counsellor's responsibility to find alternative education options for Anaya.

  After much work Anaya's Counsellor found alternative education options, none of which were suited to her needs as they were tailored for students with high behavioural management needs, and/or had long waitlists. Additionally, most options required the express support of the Education Department to enable student access. To achieve support from the Education Department the Counsellor then advocated with both the Education Department and the Department of Communities: Child Protection – this is in progress still at the time of writing this submission.

- *Accessing case management support*
  Anaya was linked to a youth outreach support service for case management and advocacy support.

Anaya's Counsellor continues to provide her with psychosocial and emotional support to assist in managing her return to education and engaging in healthy daily routines, as well as monitoring her mental health and facilitating further referrals and more formal assessment as required.

Case Study 6. Engaging mainstream mental health services to improve service access by ASeTTS' clients.

Headspace (also known as Australia's National Youth Mental Health Foundation) provides early intervention mental health services to 12-25-year-olds. The organisation provides support to young people with concerns about their mental health, physical health, sexual health, alcohol and drug use and work or study needs. They support people from diverse backgrounds, with different offices focused supporting the needs of young people in their catchment.

Headspace Cannington opened in 2021, this office is in a region that has some of the highest levels of settlement in WA.

In recognising that Headspace Cannington was supporting only small numbers of young people from CaLD backgrounds, the Centre Manager invited ASeTTS to participate in their Provider Consortium.

The Headspace Service Consortium is a collaborative advisory group that includes local service providers and organisations that partner with headspace to enhance their capacity to meet local community needs[11]. Committee members contribute their advice, support, and assistance to the Headspace service to define or identify:

- community needs and priorities,
- opportunities to collaborate and partner across service providers,
- barriers to service access by young people,
- opportunities for service expansion and innovation, and
- community education and awareness-raising activities.

Participants of the Headspace Cannington Provider Consortium include APM, ASeTTS, Centrecare, Child and Adolescent Health Services (CAHS), City of Canning, Communicare, East Metropolitan Health Services, Helping Minds, Lifeline WA, MercyCare, Neami National, and Palmerston.

Since mid-2022 ASeTTS has been an active contributor to the Consortium. While our participation was initially viewed as a vehicle to improve relationships with 'mainstream' providers and influence the scope and responsiveness of services provided to young people from refugee-like backgrounds, it has provided rich opportunities to collaborate and work together. For example, ASeTTS have engaged Headspace Cannington to deliver workshops to young people as part of our regular school holiday programs. The Headspace 'Resilience and Making Positive Connections' workshop, was introduced to the young people through games and facilitated discussion. The workshop assisted young people to both explore how to establish meaningful connections with their peers, and experience the supports provided by Headspace. This has improved young people's familiarity with Headspace services and

[11] headspace 2021, *Consortium Advisory Committee Terms of Reference*

has the potential to improve the sense of safety with Headspace, this increases the likelihood of their accessing headspace services in the future to address their mental health and wellbeing needs.

Engagement in the consortium has also led to youth mental health providers having increased engagement and interest in the needs of our clients, in our work and improved understanding of our referral processes.

Through the consortium ASeTTS have provided insights into the trends and issues impacting young people from refugee-like backgrounds, and the approach taken by ASeTTS' to provide supports and services. We view this as an important way to improve the scope and quality of services that young people from refugee-like backgrounds can access.

6. Engagement with the education system in WA

ASeTTS recognises the importance of involving schools in the recovery process and strives to work in partnership with primary and secondary schools to improve access to services by children and young people in WA.

Through nurturing positive and purposeful relationships with the Department of Education's State-wide Services Team, schools, their leaders, and educators, ASeTTS currently provides a range of services in different school settings. This includes individual counselling, services to students as outreach, and Children in Cultural Transition (CICT) and the Warriors of our Wellbeing (WOW) Programs (Refer to Table 1).

ASeTTS' staff regularly consult and network with school leaders, educators, and representatives from the Department to understand the challenges experienced within schools with regards to supporting children from refugee-like backgrounds and identifying opportunities to partner and improve supports. Despite our focus, connections with schools remains somewhat hit and miss. Some schools are very engaged and work closely with us; others have indicated that they are either too time and resource poor to do so, or do not see the benefits of engaging.

Schools that engage well are those where there is strong commitment from the Principal and Deputy Principal to both deliver the school curriculum and support students to recover from highly traumatising experiences. This is most often the leaders of Intensive English Centres (IECs), however we do note that there are dedicated educators in different mainstream schools that are deeply committed to supporting children and young people from refugee-like backgrounds to access mental health and settlement transition supports.

a. Changes to English as an Alternative Language/Dialect (EALD) supports within schools

IECs have over time experienced significant cuts in funding, which has reduced student access to English as an Alternative Language/Dialect (EALD) supports within schools. This has impacted the availability and quality of transition supports, handover to mainstream schools, supports to families to connect with school and community, and mental health supports available to students. We have received accounts of:

- Mainstream school psychologists refusing to support children from refugee-like backgrounds due to the complexity of their needs, and language barriers.

- Instances where cognitive impairment or developmental delays in children from CaLD or refugee-like backgrounds have not been identified due to school psychologists not having the skills or experience to support children from ethnolinguistically diverse backgrounds, particularly with diagnosis and assessment.

Where school staff and educators do not understand the impact of trauma experiences or trauma symptoms, they may minimise a student's support needs, and may interpret a student's behaviours as anti-social or risky. This can result in students not receiving the psychological, developmental, in-class or transitional supports needed to succeed in school. It can also lead to their being labelled as disruptive and uncooperative. Lack of support, lack of understanding and labelling in turn can lead to school refusal, and in some cases, students face exclusion or disciplinary action (refer to the next section).

The following observations are noted:

- It is our experience that if a child arrives in Australia, commencing their education at primary school age, and does not receive early trauma informed interventions and transitional supports within the school system, then their transition to high school is made more difficult. Students from refugee-like backgrounds who have not been well supported will over time develop poor school attendance or may refuse to attend school altogether. It is critical that primary school aged children from this cohort receive early intervention and transitional supports.

- Where a young person arrives in Australia and commences school at high school age, they also require tailored supports to navigate a new and unfamiliar school environment and manage competing cultural and social expectations about education. While we acknowledge that some new arrival communities have previously attended school in formal settings, others have had limited or no access to schooling; having spent several years in refugee camps. The longer a young person's experience in immigration detention or refugee camps**,** the more challenging it is to acclimate with the Australian education system and schooling requirements. Many young people that ASeTTS supports who are in high school are unfamiliar with the structure, rules, social norms, and processes of school, and ultimately struggle in to meet educational expectations (both relating to attendance and performance).

- Children and young people report struggling with the unreasonable expectations that are placed on them by the school system. For example, expectations that students will engage in school easily and quickly achieve educational targets. This includes performing at the same level as age-matched peers within tight timeframes whilst learning to read and write English.

- While children and young people from refugee-like backgrounds grow up quickly because of their experiences refugee experiences, these experiences often result in their having fewer positive social interactions with peers. They can present with difficulties trusting others, emotional dysregulation, anti-social behaviours, and delayed development. It takes time to build trust and safety with young people from refugee-like backgrounds to plan and implement the right interventions to see them grow and flourish; both in the therapeutic and educational settings.

- Where children and young people are born to refugee families and have only experienced schooling in Australia, educators have described their presentations in school as like children and young people that are newly arrived.

Case Study 7. Advocating for Education Assistance (EA) for Chewa[7]

Chewa is a 9-year-old girl born in Malaysia to Burmese parents who at the time were in unsettled circumstances as they were living in Malaysia as illegal immigrants. Chewa has an older brother by one year. Significant parental stress and trauma occurred in this period. When Chewa was 2-years of age the family arrived in Australia with refugee status. The parents appeared to settle, and Chewa's milestones and development reported as normal.

Chewa had been progressing well and without concern until she returned to school after the first term holidays in April 2022, at 8-years-of-age. At this time, she reported to the school principal, in significant detail, that she had been sexually assaulted by a male babysitter in the school holidays. The school duly reported the incident to the police and child protection. During formal investigation Chewa withdrew the allegation claiming the incident never occurred, and with that no further action was taken. Chewa's parents indicated they doubted the incident and that the alleged offender was a family friend and member of the community church.

In response to her disturbed behaviour,

- Chewa was seen by the School Psychologist. The School Psychologist supported the school by developing a behavioural management plan, positive reinforcement strategies, and self-soothing techniques.
- An Educational Assistant (EA) was engaged to work with Chewa in the classroom. They played a key role in managing Chewa's behaviours by regularly checking in with her and supporting her to regulate her emotions outside the class.
- The school made a referral for Chewa to CAMHS, and she was seen in early April 2022. The assessment by CAMHS was of an acute stress reaction. At the time CAMHS appeared to be unaware of the allegation of sexual assault. The recommendation was made for school management of Chewa's behaviours including a safety plan upon her return to school, and Chewa was discharged.
- Despite the school implementing strategies to support Chewa, her behaviour at school failed to settle.
- Chewa's parents indicated that they were not concerned and considered her behaviour in the home as within normal limits.

Chewa was referred to ASeTTS by her school in September 2022. The reason for referral was the sudden onset of aggressive and at times violent behaviour towards her peers, that she had made threats to end her life, had been wanting to run into oncoming traffic, and that school was struggling to contain her behaviour.

The initial assessment was undertaken by the ASeTTS Psychologist, who is highly experienced in working with traumatised refugee children. From the assessment it was determined that Chewa was experiencing an acute stress reaction and PTSD in response to the sexual abuse that was alleged to have occurred earlier in the year. Chewa presents with a clear diagnosis of PTSD of recent onset. Her

previous development had been uneventful. The history of trauma and stress in the back-ground history in the parents is noted and which may have led to an underestimating of the trauma reaction in Chewa and a cultural disengagement. There is a strong indication that an environment of safety and support was not provided for Chewa to discuss further the traumatic incident she experienced.

Chewa was initially engaged in weekly individual counselling sessions with gradual progression to fortnightly sessions. Safety building and trust were key factors in the developing therapeutic relationship. Early session content as raised by Chewa tended to focus on secrets and confidentiality where she discussed several hypothetical scenarios and whether this information would be told to her parents or the school. In this context regulation strategies and how to identify upsetting emotions and triggers when they emerge were developed. Chewa responded well to these interventions and has been able to identify 'bad memories' and subsequently to begin to manage her responses and feelings. To date Chewa has not discussed the content of these memories. Chewa continues to engage well in counselling and has shown improvement in being able to manage heightened emotions. There is every evidence Chewa is slowly working through the previous traumatic incident.

Engagement with her parents has remained peripheral and with a resistance to engaging in further parenting techniques.

In the school environment Chewa continues to show dysregulated behaviours, an anxiety around new children and bullying, and seeking of adult attention. Her behaviour remains highly unsettled in the school environment and is reflective of the underlying arousal of PTSD and a lack of internal safety. Ongoing behavioural strategies are in place, including periods of time out and a reward system for managing of her emotions. The role of the classroom EA remains essential in regulating Chewa's behaviour and in implementing much of the behavioural strategies. This has allowed for significant progress.

The need for an ongoing EA in the classroom is considered central to Chewa's progress for the next school year. However, it is anticipated that with resolution of symptoms this will not need to be maintained long term. The concern is that the Department will not fund EA supports for Chewa and that as a result we will collectively miss the window of opportunity to effectively resolve Chewa's symptoms. ASeTTS Psychologist and Consultant Psychiatrist have worked with Chewa's School Psychologist to explore her needs and have in late 2023 provided a letter of support to the Department of Education calling for continued classroom EA supports for Chewa.

b. ASeTTS experience of Education Department Exclusion Panels

With regards to behaviours of concern and risk of exclusion, over the past 12-months ASeTTS has been invited to participate on several Education Department Exclusion Panels as an independent expert. In each instance panels have considered the exclusion of students from refugee-like backgrounds. In each case staff sitting on panels have established that the young person at risk of exclusion has experienced layers of complex trauma. While many educators working with these students have done their best to support the student in the classroom, they have lacked understanding of trauma and trauma responses and assumed that students have behavioural issues. Again, in each case there were limited, if any, early intervention supports provided to the student, consultations with school psychologists did not occur as standard, and referrals to external supports and services were not

progressed. ASeTTS' staff have repeatedly raised the question *"If early intervention was provided would the student be facing exclusion?"*

Further, the children and young people supported by ASeTTS consistently report experiencing bullying and discrimination based on their race, cultural, religion, or refugee status within the school environment by other students. They have expressed feeling as 'other' or different from other students and have reported that the school has provided them little to no support to manage their experiences and stop bullying or discrimination from occurring.

It is our position that these experiences have a significant detrimental impact on a child or young person's mental health and wellbeing, self-perception, transition to life in Australia and engagement with school. Children and young people from refugee-like backgrounds are highly sensitive to rejection, bullying and discrimination, and 'pick up' on such issues quickly as it fits their experience of persecution. There is a need for schools to address and eliminate bullying behaviours and to support students from refugee-like backgrounds to develop resilience.

Case Study 8. Exclusion Panel intervention for a student in year 5.

In 2023 ASeTTS were invited to sit on an exclusion panel for Department of Education following an incident in a Primary School in the Northern Suburbs involving a child in year 5.

A series of separate incidents which occurred on the same day, resulted in the school applying for exclusion. The student was reported as becoming dysregulated in class and shouting at the teacher, requiring the rest of the class to leave the room to seek safety. He also struck another younger student during their lunch time. The student's in-school behaviours included aggression and intimidation towards other students and threatening self-harm and suicide.

Information provided by the Department to panellists noted that:

- The student did not have a diagnosed disability.
- Whilst the student did not have a direct experience of refugee trauma, his parents had arrived in Australia as refugees and their traumatic experiences are believed to have had an impact on the student (i.e., he experienced intergenerational trauma). Trauma, direct or intergenerational was ascribed to the student due to family history.
- The student's parents had recently separated, with mum leaving the family home following conflict with her husband. The student's behaviour was reported as escalating after the separation, with behaviours attributed to the student 'feeling rejected' by his mother.
- Further, the student's father had recently had a heart attack, further complicating the child's feelings of loss and potential abandonment.
- The panel noted that the student's father had limited parenting skills and had sought a lot of support from the school. Despite referrals and recommendations made to the student's father, dad did not follow through with parenting support programs such as the Triple P Program or the Family Support Network.

On interview by the exclusion panel, the student stated that he became angry that day when other children chased away an insect that he was caring for. According to the student, he loved the insect, and the insect also loved him. The child explained to the panel that when he grows up he wants to work in nature, or in an area that helped to look after animals.

He admitted to becoming angry and striking other children but indicated that this was in response to another student stomping on millipedes even after he asked him to stop. The student indicated that on both occasions he became extremely angry and could not control his behaviour.

While the school states that they tried to implement supports to the student these fell short. Due to cultural and language barriers, and the school's failure to use interpreters in initial phone calls, the student's father did not understand what actions needed to be taken. This includes how to follow up on a mental health care plan for his son and did not pursue other supports.

Whilst the student's behaviours were inappropriate, the school failed to consider the student's trauma experiences in their assessment of his exclusion. ASeTTS involvement in the panel resulted in a trauma lens being applied rather than focusing solely on behaviours of concern.

The student's response to perceived disrespect or ambivalence towards insects seemed to trigger his feelings of abandonment, as this was something he cared for. These behaviours, while inappropriate, were a response to the student's primary attachment leaving and another becoming ill. It could also be argued that the family having settled from another country meant that mental health and other supports were a foreign concept, and that more intensive referral processes were needed to engage the family in external supports.

ASeTTS were also able to present the idea that an exclusion from his school and peers would further these feelings of abandonment for the child as this is the only consistent factor in his life at this stage. Rather than exclusion, ASeTTS staff advocated for a supported learning environment and a warm referral process to support agencies where interpreters could be accessed for the parents. This was agreed by the rest of the panel and accepted by the Director General. The student was not excluded from school, instead his needs were considered, and the school was instructed to look at strategies to better address his needs.

c. Barriers to working in the school environment

As this section highlights a considerable amount of ASeTTS services to primary and high school aged students is delivered within the school environment. This approach is beneficial as schools provide a stable and safe environment for the delivery of support and in some ways encourages school attendance by the student.

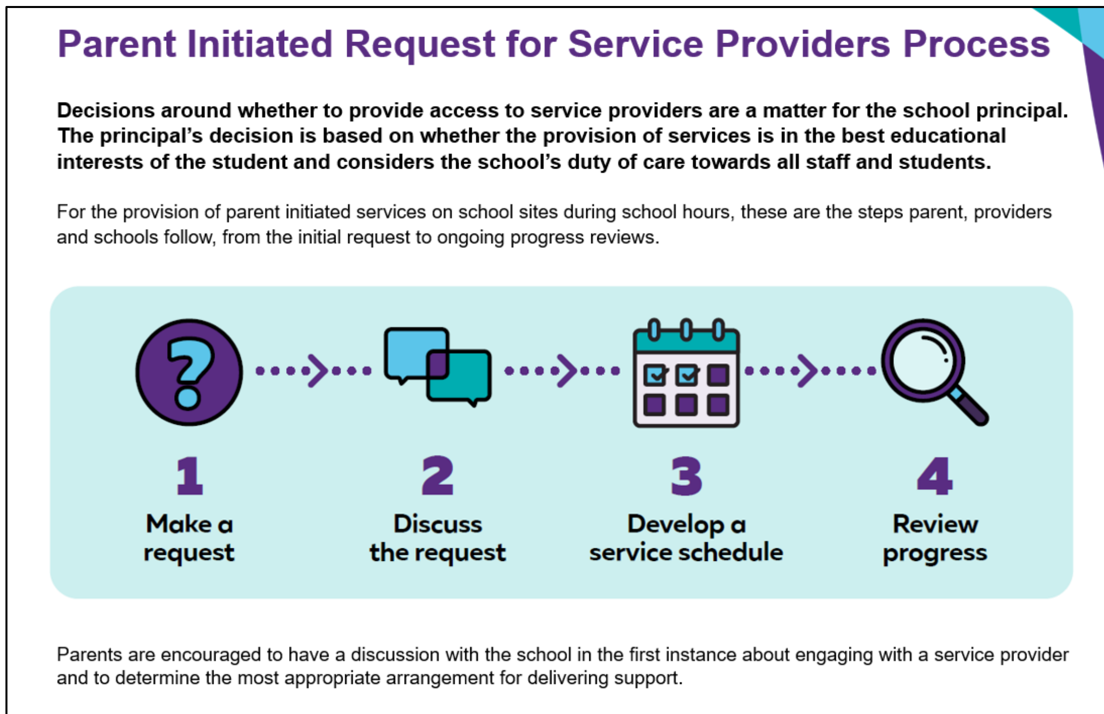
At the end of the 2023 school year and the start of 2024, public schools in the Perth metropolitan area have implemented changes to their policies regarding external providers delivering services to students on school premises. The changes require providers to ensure that staff who work with students at school have completed a Criminal History Screening for Department of Education Sites/Nationally Coordinated Criminal History Check (NCCHC), can provide current Working with Children Check, and provide details about the organisation's public liability and professional indemnity insurances. The new protocols also require that a formal request be submitted to the School Principal (by parents or the provider) for services to be provided at school.

We note that the protocols are being implemented very inconsistently across schools, in some cases schools are focused on ensuring the continuity of supports and in others it appears the protocol is being applied to deny access to Counsellors. We understand the need for schools to always ensure a

child safe environment, manage the volume of requests for in-school services and ensure services do not impact a student's access to education, or impact other students and staff. We do however have concerns that there will be inconsistency between schools, where some Principals will, without deep understanding of individual student needs and complex trauma, deny students from refugee-like backgrounds access to ASeTTS services.

> *"Principals can deny access to the provider if they determine the service does not support the student's learning needs, access to education and impact on student learning, can be accessed outside of school or have an adverse impact on the school, staff or other students"*[12].

Figure 6. Department of Education protocols regarding request for service provider support[13]



7. Previous input into the mental health needs of children and young people

We note that this is not the first time ASeTTS have submitted information to representatives of government about the trauma and support needs of children and young people from refugee-like backgrounds. For example, in 2020-2021 ASeTTS' leadership contributed significant time and energy contributing to the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in Western Australia, which was focused on improving publicly available mental health services to young people who are under 18 years-of-age.

While the efforts taken by the Taskforce are acknowledged, ASeTTS' employees, Executive and Board have concerns about the taskforce's approach to consultation, its final report, and findings. Our concerns included that:

- Out of hundreds of people contributing their expertise as people with lived experience, interagency experts, and clinical experts, only ASeTTS' CEO and a member of the Multicultural

[12] Department of Education 2021, *Provider information. Parent initiated service provider for students with disability.* Dept. of Education: Perth, WA

Futures Mental Health Team were invited to represent all CaLD peoples and communities, and multicultural service providers in WA.

- There was a lack of consultation with CaLD people and people from refugee-like backgrounds, and no representation of CaLD or refugee people on the Lived Experience Expert Advisory Group.

- The Taskforce's final 171-page report provided only superficial insights into the public mental health service needs of CaLD children, families, and communities. It provides no depth beyond referring to the need for services to be *"…culturally-responsive and inclusive" and* appeared to frame CaLD peoples as a homogenous group with uniform needs. There was no reference whatsoever to children and young people from refugee-like backgrounds, and no consideration of the complex trauma experienced by children and young people from refugee and asylum seeker backgrounds.

While ASeTTS agreed with the Key Insights presented in the Taskforce's Final Report we did provide the feedback about each of the insights (refer to Table 2). We note that that there have been no follow up actions taken to explore the needs of children and young people from refugee-like backgrounds following the completion of the Taskforce's work. It is our view that these recommendations remain relevant to this point in time.

Table 2. ASeTTS' responses to the Ministerial Taskforce's Final Report Key Insights (September 2021)

Key Insight	ASeTTS' feedback
Key insight 3: The experience of some children, family and carers is poor and is potentially harmful	*"…being told they are not unwell enough to be accepted into a service…"* is particularly true for young people from a refugee-like backgrounds. The public mental health system appears focused on how to exclude young people from services and reacting to actual risk and crisis, rather than providing meaningful early supports and interventions.
Key Insight 4: Current services do not operate as a coherent infant, child, and adolescent system	While we applaud the WA Government's commitment to fund an additional 100 school psychologist positions, we urge the government to consider other areas of investment to improve services to children and young people from CaLD and refugee-like backgrounds.
Key Insight 5: Demand for services is increasing at a much higher rate than investment in capacity	The needs of children and young people from refugee-like backgrounds are not being met, including by our own services. It is our view that this is a critical gap that must be addressed with urgency.
Key Insight 8: A lack of community alternatives places increasing demands on emergency departments that are already under pressure	The paper places significant focus on reacting to existing mental health needs and crisis. While this remains important, there is a need for investment in prevention, psychoeducation, and early intervention supports – not purely services that are responding to crisis. Investment in early supports and services would go some way to alleviate pressures on emergency departments, and reduce the distress experienced by infants, children, and adolescents.

Key Insight	ASeTTS' feedback
Key Insight 9: There are critical gaps in the range of services currently provided to children and families	Services to children from ethnolinguistically diverse communities and refugee-like backgrounds appear to have been forgotten in the list of critical gaps in service. In fact, children and young people from CaLD and refugee-like backgrounds are invisible throughout the paper.
Key Insight 10: 0-to-17-year-old children are presenting with increasingly complex issues	We note that coordinated services and treatment is required where a child is exposed to various external traumatising factors (e.g., settlement into a new country and culture) and multiple service providers have input. Disconnected and fragmented services create additional problems for children, young people, families, and communities – and can themselves be traumatising. This is particularly the case children and young people from ethnolinguistically diverse backgrounds who navigate two cultures.
Key Insight 11: Access to children and families in regional, rural and remote WA is not equitable	There are currently no generalist or specialised mental health services available for children from CaLD and/or refugee-like backgrounds outside the Perth metropolitan area.
Key Insight 12: Public services are not designed to meet the needs of Aboriginal children and families	We recognise the significant trauma that First Nation peoples have experienced and believe there are some similarities in the experiences of the children, adults, families, and communities we support (e.g., forced displacement, removal from families, human rights violations, and torture and trauma). The principles as outlined in the Emerging Directions for improved support to address the needs of Aboriginal children and families could also apply to developing culturally sensitive services for children from CaLD and refugee-like backgrounds. Public services are currently not designed to meet the needs of children, young people, and families from CaLD and refugee-like backgrounds.
Key Insight 13: At-risk children with specific needs are missing out on treatment and support	We appreciate children from CaLD backgrounds are listed as an at-risk group that has challenges in accessing timely and appropriate public mental health services and agree that there is a need to gather further information and data. We urge the taskforce to consider the needs of children from refugee-like backgrounds further in their review; and remind the taskforce that children, young people, and families from CaLD and/or refugee-like backgrounds do not have homogeneous need, beliefs, and experiences. Any review should consider the diversity of backgrounds, experiences, beliefs, and needs.
Key Insight 14: Capacity and capability issues with	We recommend investment to increase workforce capability to support ethnolinguistically diverse people, and increased representation of

Key Insight	ASeTTS' feedback
the workforce impact service delivery	ethnolinguistically diverse people within the mental health workforce at all levels.

8. ASeTTS' recommendations to improve supports to children and young from refugee-like backgrounds that have experienced trauma

In preparing this submission we have strived to provide a clear explanation of the breath, depth, and complexity of ASeTTS' work in supporting children and young people (and their families) from refugee-like backgrounds to recover from direct or indirect torture and trauma experiences and adjust to life in a new country. We have outlined that we support children, young people and families from extremely diverse cultural identities, language groups, beliefs and experiences and deliver varied supports, services, and programs to respond to these different needs, and to needs as they change across time.

Despite our decades of experience delivering meaningful supports to refugee survivors of torture and trauma, we are acutely aware that our resourcing limitations reduces our capacity to meet the true demand for trauma recovery services. We also understand that ASeTTS' alone cannot meet all community needs. There is a need for organisations like ASeTTS to develop strong partnerships and collaborations with other multicultural and community organisations, with schools and educators, and with community and public mental health services to develop well-rounded and considered supports. It is our vision that children and young people from refugee-like backgrounds will have access to timely and effective services from a strong and properly resourced network of community and public providers and schools. We hope for a future where all supports provided to young people from refugee-like backgrounds are trauma-informed and culturally considered, and that providers and agencies communicate well and work in partnership to deliver positive outcomes.

To improve the support provided to children and young people who have been directly or indirectly exposed to trauma associated with migration to Australia due to humanitarian crises we make the following recommendations to the Joint Standing Committee.

1. **Specialist refugee mental health providers and programs require committed, ongoing funding.**
   Organisations that currently support children and young people from refugee-like backgrounds are woefully under-resourced, and as a result cannot meet the true demand for services. Under resourcing makes it difficult for service provider organisations to recruit and retain a specialist and highly qualified workforce with experience in supporting children and young people impacted by refugee-trauma. It also makes it challenging to deliver long-term or ongoing supports to traumatised individuals, we instead focus on short-term initiatives and programs that dip in and out of a young person's life.

   Our experience in delivering long-term counselling to trauma impacted people from refugee-like backgrounds tells us that healing takes time and continued and consistent engagement. As does acclimating to life in Australia and navigating the complexities of living between cultures.

   Separately, before establishing new services and funding initiatives for children and young people from refugee-like backgrounds we urge the government to review and consider existing services and the organisations that deliver them. There is merit is ensuring existing services are

appropriately resourced and supported to deliver quality recovery outcomes to children, families, and communities. Services, both public and community are not currently well resourced, this limits what can be reasonably delivered.

2. **Embed cultural awareness and cultural safety practices across public and community mental health services.**
   While we acknowledge that children and young people from refugee-like backgrounds (including asylum seekers) are eligible to access public and community mental health services, young people and their families tell us that services are not culturally safe and that workers often have limited understanding of their experiences and trauma. To ensure there is equitable access to services by children and young people from refuge-like backgrounds, we recommend investment in training of public and community mental health staff in cultural awareness and cultural safety practices. Responsibility for supporting this group of children and young people should not rest with a small number of organisations or a discreet number of CAHS, CAMHS and headspace clinicians. All clinicians should strive to provide culturally safe and trauma informed services.

   It is our view that if there is improved cultural awareness that children and young people will have improved access to the services they need. Rather than engaging in a complex process of proving the child or young person truly requires support, they could access timely and culturally secure services when they need them.

3. **Public mental health services should consider delivering preventative services rather than waiting until children and young people and their families are in crisis.**
   We recognise the resourcing limitations in public mental health services and that these limitations reduce the general availability of services to all children and young people in WA. As highlighted in the *2021 Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents Final Report*, public mental health services need to strengthen their focus on delivering meaningful preventative services, psychoeducation and early intervention supports.

   By making children, young people and families wait for services until they are in crisis, creates additional trauma and problems. Adding to their existing trauma-load.

4. **Increase school-based services and supports that assist children from CaLD and refugee-like backgrounds and develop consistent approaches to engaging external specialist supports.**
   We note that with changes to the resourcing of public schools' specialist multicultural support resources have significantly reduced, this includes within Intensive English Centres (IECs) who support children from refugee-like backgrounds. While ASeTTS strives to work collaboratively with IECs, each IEC operates very differently. We have identified that some educators, Principals and Deputy Principals place value on students accessing tailored in-school mental health and wellbeing supports (e.g., individual and/or group therapy solutions), others deny access to external providers or use Department of Education policies to prevent engagement with students from refugee-like backgrounds.

It is our view that students from refugee-like backgrounds require place-based supports to assist them in exploring their trauma experiences, their strengths, gifts, and developing supportive friendships and relationships with peers. From experience these services are more effective when delivered in partnership with students, parents, and educators. We understand the pressures that schools face in managing the multiple complex needs of students, but call on schools to remain open to working with organisations like ASeTTS to resolve the trauma symptoms of students.

5. **The voices and experiences of children, young people and families from refugee-like backgrounds should be heard and considered in the development of service improvements.**
   We recommend that people from refugee backgrounds be widely consulted as part of identifying good practices and what is needed to bridge services from current practices and service offerings to desired future state.

   The people we support often have a clear understanding of what is needed but lack a 'seat at the table', this has been evident in recent consultations relating to mental health services including the Ministerial Taskforce.

Finally, ASeTTS is keen to contribute further to any work of the Joint Standing Committee on the Commissioner for Children and Young People.

We welcome enquiries about this report and ask that enquiries be directed to the ASeTTS' CEO, Ms Merissa Van Der Linden at ceo@asetts.org.au.

Yours sincerely,

Merissa Van Der Linden
Chief Executive Officer, ASeTTS
Date: 28 February 2024

Appendix. Young people's exposure to war and conflict in media. A guide for schools and community members

MEDIA COVERAGE OF WAR, CONFLICT AND OTHER TRAUMATIC EVENTS

In recognising the ongoing violence and suffering occurring in various regions across the world, it is important that adults remain aware and vigilant of the media that children and young people are exposed to related to these events.

Media from conflict areas can also be used to fuel cultural and faith-based discrimination and abuse in Australia, which greatly impacts children and young people in the community.

Social and traditional media are useful tools enabling children and young people to connect to each other and their communities, but it is important to recognise the potential risks. Media often covers the most frightening and graphic aspects of war, conflicts and other traumatic events. Graphic images, audio and video recordings of these events circulate widely online. With such widespread access to social media and other digital platforms, it can be hard to predict where and when children and young people may access such material, making it even more important that their screentime and access to devices are monitored and discussed.

For many children and young people from refugee backgrounds, family members may continue to be living in dangerous situations or conflict locations. It is stressful and possibly overwhelming to hear news of family members in danger.

Parents and children may struggle with the strong emotions of wanting to protect family they are separated from, while being extremely limited in their ability to do this. Some parents may become very preoccupied with the danger their family members are experiencing and not realise how much media their children are being exposed to.

About us

ASeTTS provides services to people who are humanitarian entrants or are from a refugee type background and who have experienced torture or trauma in their country of origin, during their flight to Australia, or while in detention.

This resource has been prepared for teachers and community members who are caring for, or working with, children and young people who are survivors of refugee trauma, including intergenerational trauma. For capacity building and educators' training on working with students from refugee backgrounds, contact the ASeTTS team if you would like to refer someone into our program on 08 9227 2700 or visit our website.

ASeTTS acknowledges that this resource has been developed and generously shared by its sister agency QPASTT.

IMPACTS OF MEDIA COVERAGE

Younger children (under 8 years of age) are particularly at risk of experiencing difficulties making sense of traumatic images, sounds and information in the media. Developmentally, they will struggle to distinguish place and time, or understand that repeated media coverage is not multiple events. They may become worried about their safety and for the safety of their family (in Australia and overseas). Media exposure may trigger traumatic memories from experiences prior to their arrival in Australia.

For older children (8-12 years) it is important to recognise that they may not be mature enough for the repetitive and often graphic coverage of ongoing conflicts. For all children, witnessing mass violence and seeing adults and other children harmed or in distress can be extremely frightening.

TRAUMA RESPONSES IN CHILDREN AND YOUNG PEOPLE

For all children and young people, it can be helpful to recognise signs of an acute stress response including:

- Uncertainty, worry and nervousness
- An inability to concentrate
- Difficulties managing emotions, including anger, sadness and fear
- Low mood, reduced motivation and reduced enjoyment of activities
- A need to keep busy
- Difficulty with sleep including nightmares
- Fear of being separated from parents or caregivers (particularly children)
- Feeling powerless or hopeless

For all people, but particularly children and young people, being exposed to media coverage of war and conflicts may trigger memories, nightmares and flashbacks of previous traumatic experiences. It is also important to recognise that flashbacks are more than a memory. A flashback is a visceral recall of past experiences to the point that it feels like the trauma is occurring again. This can cause extreme fear, making it very difficult to convince the person they are not at acute risk of harm.

Teens and young adults are likely to absorb the news independently, often through platforms such as TikTok and Instagram. Monitoring screentime can be difficult so continuing to check in without blame or judgement is important. Older youths are more likely to be aware of the impact of the conflict in their own communities, which may impact their emotional wellbeing.

For teachers and school staff it is important to remember that even if students are not accessing the media at school, they may still discuss what they have seen at home, in the classroom and playground.

What can you do to help?

Schools and communities can play an important role in supporting individuals who are impacted by ongoing and emergent situations. If children or young people are exhibiting signs of distress, check on their wellbeing and offer options for support.

This may be:

- Allowing them to spend time in a quiet space (inside or outside the classroom)
- Speaking with a trusted adult
- Connecting them to the school's wellbeing staff
- Offering calming activities

To engage with students and parents, teachers and school staff may need to access language support. Western Australia state school staff can find a translator or interpreter or engage a qualified interpreter through the Translating and Interpreting Service (TIS) using the Department of Education's client code CUAITS2017 or phoning 131 450.

TIPS FOR TALKING TO YOUNG PEOPLE ABOUT WAR AND CONFLICT

Find out what they already know and how they feel about it

It is important to find out what a child or young person already knows before you begin discussing war, conflict and other traumatic events. This ensures you do not share information they are not ready for. This may include checking in on how their family and community is affected. Depending on a young person's age and level of distress, it may be more appropriate to check with parents and carers directly.

Keep it calm and age-appropriate

Use age-appropriate language, watch their reactions, and be sensitive to any fear, worries or anxiety.

Normalise emotions

It can be extremely reassuring and calming for an adult to convey to a child or young person that their emotional reaction has been noticed, is important and a normal response to conflict or frightening events. Keeping yourself calm and listening with kindness can help someone feel better.

Spread compassion, not stigma

Try to avoid judgement and instead encourage compassion. Unfortunately, discrimination can be common during times of conflict and children and young people from refugee backgrounds may be exposed to higher amounts of racial or religious commentary, discrimination or bullying.

Focus on the helpers

It is important to remind children that people are helping each other with acts of courage and kindness. This sense of people taking positive action can provide great comfort.

Close conversations with care

It is important not to leave children and young people in a state of distress. Always remind them that you care and you are there to listen whenever they need support.

Continue to check in

Given the ongoing nature of conflict, it is good to check in with children and young people. Be prepared to speak with them if they raise the subject.

Limit the flood of news

Children's development can affect their ability to process the information they are receiving. Wherever possible, try to reduce their consumption by switching off screens or limiting how much you talk about the situation.

As families may be directly affected, media might serve an important purpose. Focus on discussing how family members can continue to remain informed while considering their timing, location and modes of media consumption to reduce exposure for children and young people. It can be as simple as using headphones if they are listening to information.

Redirect away from media

Engage children in activities that provide respite from the media. This might be playing a game, going for a walk or anything that you know is soothing or grounding for them.

TIPS FOR TALKING TO YOUNG PEOPLE ABOUT WAR AND CONFLICT - CONTINUED

Take care of yourself

As trusted adults, you may find that children and young people reach out to you for assistance. It is important that you remain aware of what is occurring so that you are in the best position to provide support. In doing so, you should remember to take care of your own wellbeing and know your limits - if it becomes too much, ask for help.

Stay informed. Try to be prepared for questions that might arise. Be willing to acknowledge situations are often complex and you might not fully understand what is happening and why. In doing so, be mindful of how much media you consume yourself.

Be prepared. Get to know your community and the children and young people you are working with. This can help with knowing when conflicts might affect some community members more than others, and who you can reach out to for support.

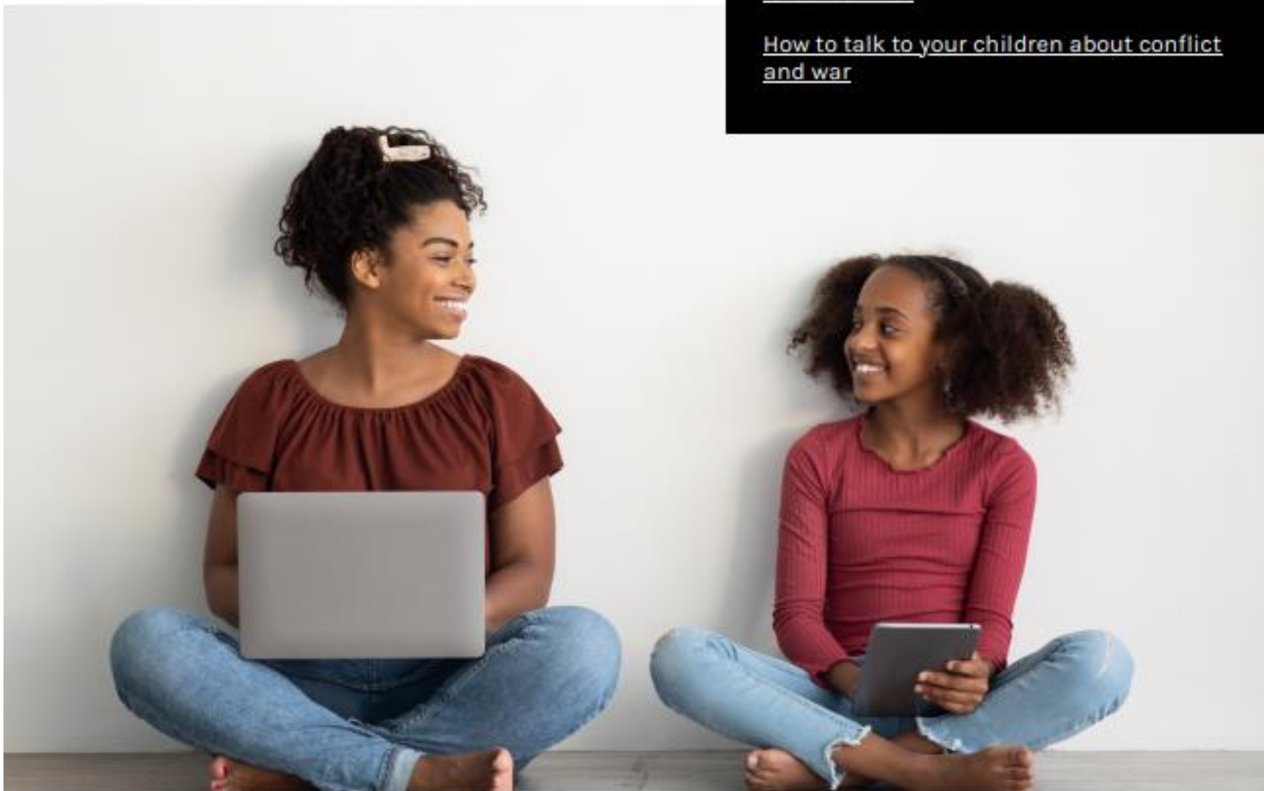
Follow up. Discussing traumatic situations can be difficult for everyone. If you notice yourself becoming anxious or upset, it might be helpful to debrief with a colleague or seek support for yourself. Children and young people will pick up on your response to the news. It is important that you take care of yourself so you are able to support others.

Useful Links

Explaining the News to Our Kids

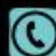
How to talk to children about the Hamas-Israel conflict

How to talk to your children about conflict and war



Contact us for more information

286 Beaufort Street Perth WA 6000

 (08) 9227 2700

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